

# DELINEATION OF CLINICAL PRIVILEGES - NUCLEAR MEDICINE

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

|  |               |             |
|--|---------------|-------------|
| 1. NAME OF PROVIDER <i>(Last, First, MI)</i> | 2. RANK/GRADE | 3. FACILITY |
|--|---------------|-------------|

**INSTRUCTIONS:**

**PROVIDER:** Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

**SUPERVISOR:** Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

| PROVIDER CODES   | APPROVAL CODES   |
|--|--|
| 1 - Fully competent to perform<br>2 - Modification requested <i>(Justification attached)</i><br>3 - Supervision requested<br>4 - Not requested due to lack of expertise<br>5 - Not requested due to lack of facility support | 1 - Approved as fully competent<br>2 - Modification required <i>(Justification noted)</i><br>3 - Supervision required<br>4 - Not approved, insufficient expertise<br>5 - Not approved, insufficient facility support |

## SECTION I - CLINICAL PRIVILEGES

**Category I.**

Includes practitioners who have completed a limited training program in nuclear medicine, such as part of an accredited residency. Under this category of privileges, practitioners may perform and interpret procedures only within a specialized area of nuclear medicine (e.g. heart, thyroid).

| Requested | Approved |                                |
|-----------|----------|--------------------------------|
|           |          | Category I clinical privileges |

**Category II.** Includes Category I.

Includes practitioners who have completed a minimum of six months of nuclear medicine training, involving all organ systems, in an accredited program, but are not necessarily board certified. Under this category practitioners may perform and interpret in multiple areas but must request consultation to perform or interpret modified or new procedures, or when the diagnosis is in doubt.

| Requested | Approved |                                 |
|-----------|----------|---------------------------------|
|           |          | Category II clinical privileges |

**Category III.** Includes Categories I and II.

Includes practitioners who have completed eighteen months of nuclear medicine training in an accredited program, but who are not necessarily board certified. Under this category practitioners may perform and interpret in multiple areas but must request consultation when the diagnosis is in doubt.

| Requested | Approved |                                  |
|-----------|----------|----------------------------------|
|           |          | Category III clinical privileges |

**Category IV.** Includes Categories I, II and III.

Includes practitioners who have specialty certification granted by the American Board of Nuclear Medicine, the American Board of Radiology with Special Competence, or their equivalent. Members in this category may perform and/or interpret procedures on a full-time basis without consultation.

| Requested | Approved |                                 |
|-----------|----------|---------------------------------|
|           |          | Category IV clinical privileges |

## DIAGNOSTIC NUCLEAR MEDICINE

| a. In-vivo imaging and non-imaging evaluations using radiopharmaceuticals. All organ systems. <i>(Specify imaging systems below.)</i>   | b. In-vivo imaging and non-imaging evaluations using radiopharmaceuticals. Limited to <i>(Specify organ systems):</i> _____ <i>(Specify imaging systems below.)</i> |                                    |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|---|---|------------------------------------|--|--|--|------------|--|--|-----------|--|--|------------------------------------|---|-----------|----------|--|--|--|------------|--|--|-----------|--|--|------------------------------------|
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 10%; padding: 5px;">Requested</th> <th style="width: 10%; padding: 5px;">Approved</th> <th style="width: 80%; padding: 5px;"></th> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td>(1) planar</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td>(2) SPECT</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td>(3) PET (coincidence or dedicated)</td> </tr> </table> | Requested   | Approved                           |  |  |  | (1) planar |  |  | (2) SPECT |  |  | (3) PET (coincidence or dedicated) | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 10%; padding: 5px;">Requested</th> <th style="width: 10%; padding: 5px;">Approved</th> <th style="width: 80%; padding: 5px;"></th> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td>(1) planar</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td>(2) SPECT</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td>(3) PET (coincidence or dedicated)</td> </tr> </table> | Requested | Approved |  |  |  | (1) planar |  |  | (2) SPECT |  |  | (3) PET (coincidence or dedicated) |
| Requested   | Approved  |                                    |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|   |   | (1) planar                         |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|   |   | (2) SPECT                          |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|   |   | (3) PET (coincidence or dedicated) |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
| Requested   | Approved  |                                    |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|   |   | (1) planar                         |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|   |   | (2) SPECT                          |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |
|   |   | (3) PET (coincidence or dedicated) |  |  |  |            |  |  |           |  |  |                                    |   |           |          |  |  |  |            |  |  |           |  |  |                                    |

## THERAPEUTIC NUCLEAR MEDICINE

| Requested | Approved |   |
|-----------|----------|---|
|           |          | a. Treatment of patients using radiopharmaceuticals. All radioisotopes.   |
|           |          | b. Treatment of patients using radiopharmaceuticals that is limited to <i>(Specify radioisotopes and/or procedures, e.g., I-131 for hyperthyroidism):</i> |
|           |          |   |
|           |          |   |

| IN-VITRO NUCLEAR MEDICINE  |          |   |           |          |                 |
|--|----------|---|-----------|----------|-----------------|
| Requested  | Approved |   |           |          |                 |
|  |          | a. Laboratory type studies including radioimmunoassay and blood volume/component analysis using radiopharmaceuticals. All procedures.                                 |           |          |                 |
|  |          | b. Laboratory type studies including radioimmunoassay and blood volume/component analysis using radiopharmaceuticals that is limited to <i>(Specify procedures)</i> : |           |          |                 |
|  |          |   |           |          |                 |
|  |          |   |           |          |                 |
| ADDITIONAL PRIVILEGES  |          |   |           |          |                 |
| Requested  | Approved |   | Requested | Approved |                 |
|  |          | a. Bone Densitometry  |           |          |                 |
| COMMENTS   |          |   |           |          |                 |
|  |          | SIGNATURE OF PROVIDER   |           |          | DATE (YYYYMMDD) |
| SECTION II - SUPERVISOR'S RECOMMENDATION   |          |   |           |          |                 |
| Approval as requested <input type="checkbox"/> Approval with Modifications <i>(Specify below)</i> <input type="checkbox"/> Disapproval <i>(Specify below)</i> <input type="checkbox"/> |          |   |           |          |                 |
| COMMENTS   |          |   |           |          |                 |
| DEPARTMENT/SERVICE CHIEF <i>(Typed name and title)</i>   |          | SIGNATURE   |           |          | DATE (YYYYMMDD) |
| SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION   |          |   |           |          |                 |
| Approval as requested <input type="checkbox"/> Approval with Modifications <i>(Specify below)</i> <input type="checkbox"/> Disapproval <i>(Specify below)</i> <input type="checkbox"/> |          |   |           |          |                 |
| COMMENTS   |          |   |           |          |                 |
| CREDENTIALS COMMITTEE CHAIRPERSON <i>(Name and rank)</i>   |          | SIGNATURE   |           |          | DATE (YYYYMMDD) |

# EVALUATION OF CLINICAL PRIVILEGES - NUCLEAR MEDICINE

*(For use of this form, see AR 40-68; the proponent agency is OTSG.)*

|  |  |   |
|--|--|---|
| 1. NAME OF PROVIDER <i>(Last, First, MI)</i> | 2. RANK/GRADE  | 3. PERIOD OF EVALUATION <i>(YYYYMMDD)</i><br><br>FROM                      TO |
| 4. DEPARTMENT/SERVICE                        | 5. FACILITY <i>(Name and Address: City/State/ZIP Code)</i> |   |

**INSTRUCTIONS:** Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

## SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

| CODE | PRIVILEGE CATEGORY  | ACCEPTABLE | UN-ACCEPTABLE | NOT APPLICABLE |
|------|---|------------|---------------|----------------|
|      | Category I clinical privileges  |            |               |                |
|      | Category II clinical privileges   |            |               |                |
|      | Category III clinical privileges  |            |               |                |
|      | Category IV clinical privileges   |            |               |                |
|      | <b>DIAGNOSTIC NUCLEAR MEDICINE</b>  |            |               |                |
|      | a. In-vivo imaging and non-imaging evaluations using radiopharmaceuticals. All organ systems. <i>(Specify imaging systems below.)</i>                                 |            |               |                |
|      | (1) planar  |            |               |                |
|      | (2) SPECT   |            |               |                |
|      | (3) PET (coincidence or dedicated)  |            |               |                |
|      | b. In-vivo imaging and non-imaging evaluations using radiopharmaceuticals. Limited to <i>(Specify organ systems):</i> _____ <i>(Specify imaging systems below.)</i>   |            |               |                |
|      | (1) planar  |            |               |                |
|      | (2) SPECT   |            |               |                |
|      | (3) PET (coincidence or dedicated)  |            |               |                |
|      | <b>THERAPEUTIC NUCLEAR MEDICINE</b>   |            |               |                |
|      | a. Treatment of patients using radiopharmaceuticals. All radioisotopes.   |            |               |                |
|      | b. Treatment of patients using radiopharmaceuticals that is limited to (Specify radioisotopes and/or procedures, e.g., I-131 for hyperthyroidism):                    |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |
|      | <b>IN-VITRO NUCLEAR MEDICINE</b>  |            |               |                |
|      | a. Laboratory type studies including radioimmunoassay and blood volume/ component analysis using radiopharmaceuticals. All procedures.                                |            |               |                |
|      | b. Laboratory type studies including radioimmunoassay and blood volume/ component analysis using radiopharmaceuticals that is limited to <i>(Specify procedures):</i> |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |
|      | <b>ADDITIONAL PRIVILEGES</b>  |            |               |                |
|      | a. Bone Densitometry  |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |

**SECTION II - COMMENTS** *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR

SIGNATURE

DATE (YYYYMMDD)